CALIFORNIA DEPARTMENT OF Mental Health

2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES
DATE: August 2, 2011 LOCATION: Sacramento, CA

Participants

17 Consumers/Family Members/Consumer Advocates
17 Providers
10 County Representatives
34 Other
181 Phone Participants
259 Total Participants

Pre-Meeting Education Session- Questions and Comments

- The use of realignment language is confusing due to Realignment 1 (1991). The current effort is "realignment of approval to local level"
    - AB100 = changes in plan review responsibility more efficient way to provide input into county plans.
- AB100 Workgroup is determining oversight functions.
- A102 outlines Administrative functions
- DHCS does Medi-Cal oversight for whole system; the move to DHCS houses ALL functions to one entity.
- What happens when you have services and programs with a mixture of funding streams (including M/C)?
    - Funding is blended but the intention of funding streams causes confusion/challenges
- Recovery principles are critical, but they are not a part of the medical model of services.
- What happens to the WET contracts administered by DMH (e.g., CalSWEC)?
- What considerations are being made with data collection (M/C claims, etc.)?
- It make sense to realign to local level only if locals know what they are doing:
    - Rural – not as big of base of history with MHSA
    - Knowledgeable staff retire/attrition
    - Reluctance to hire consumers
- There are unique challenges for small counties.
- This change (transfer of Medi-Cal) is centralizing a function that has been sub-contracted to DMH.
- Blended funding used to maximize resources; does not necessarily mean that the transfer to DHCS will change the program/intention
- Blending funding in counties:
    - Funding drives programs
    - Reversals to other types of services as resources/funding go down

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Stakeholder Process and Design Input

- Where does the MHSOAC have a role?
  - MHSOAC = oversight & accountability and technical assistance
- Oversight is a huge issue that needs to be discussed and determined.
- The functions handout is a [partial] list of functions that are "left over" Community Services Division (DMH) functions/activities/programs.
- Compliance reviews also look at Realignment structures, Boards/Commissions
- Mental Health Functions Handout:
  - People in the counties won't know what is happening/function at the state level (providers might know).
  - Un-served communities will not want to fill out this handout at the local level
  - People want to be asked, "what is important to you?" or "what do you want/expect from the state to help at local level?"
  - What do we want the partnership to be between the county and the state?
- Continuum of Education:
  - What are you asking stakeholders to make a decision on?
  - Community and consumers – what are the needs from the un-served and underserved communities
  - After education (down the road), there is not enough time to do this today
- Be more direct to say what steps should/are being implemented to protect existing programs like the California Reducing Disparities Project.
- Performance contract monitoring is the charge of MHSOAC:
  - Across the lifespan
  - Adherence to MHSA values

General Stakeholder Session- Questions/Comments

- This is a cumulative stakeholder process and full participation can be a burden for organizations with limited budgets. Are funds available to support travel?
- George Hills/CalMHSA should be included in this stakeholder process.
- Regarding the schedule, will there be a "regional" stakeholder meeting in Sacramento?
- Office of Consumer and Family Affairs is a function that should be included, as well as:
  - State Quality Improvement Council
  - Compliance Advisory Council
  - Client Family Taskforce
- These are profound structural changes; you need to engage as many stakeholders as possible:
  - Auditorium setting make people comfortable

  - Consider smaller groups to allow more participation
- Mental health and substance abuse continue to be “ugly ducklings”. We need to continue to pay attention to Mental Health and Substance Use Disorders in the context of integration. There are further disparities in access and quality of care.
- Licensing/certification missing from the functions list.
- It would be helpful to know more about what DMH does well; think about not transferring those functions that DMH has succeeded with.
- Central leadership on terms of policy; statewide focus to maintain standards of MHSA.
- There needs to be statewide oversight of local planning processes.
- Providing interpreters is not the only aspect of cultural competence:
  - the venue/parking/location not friendly for communities
- Who are the target populations for these meetings? How does this activity improve care for people in the communities (especially for racial, ethic, linguistic, cultural groups)?
  - One month of meetings is not enough time. It takes time to prepare people from un-served and underserved communities to participate in this type of stakeholder process.
  - Get local people who are already working with un-served and underserved populations to help with outreach
- Challenges:
  - Co-occurring disorders
  - Stigma and discrimination
  - Unique characteristics of the service system
    - Client family driven
    - Cultural competence
- The CA Mental Health Planning Council recommends a stand alone mental health department that reports to CHHS.
- Mental health parity—there are too many clients/caseload issues in the system
- Need to consider health care reform, integrated services, and systems of care
- Use of MHSA funding created a dual system. No one is answering stakeholder questions about this issue. When is MHSA going to be integrated?
- There are challenges for family members, like getting to meetings. There are transportation and child care issues. Will there be options or stipends so that family members can attend the meetings?
- Family voices need to be heard – we need to think more about how to ensure participation
- Need to continue state level oversight and accountability to ensure counties addressing stakeholder concerns/needs
- Cultural competence: we need to include African Americans.
- Cultural competence/strategies to engage:
  - There are [more than] 80 federally recognized tribes with their own governments
  - There are no evidence based programs for Native peoples

  - We need to focus on engaging California's Native American tribes/people in this stakeholder process
- Concerned about the limitation of choosing only (5) priority area/functions need to preserve more than five.
- OMS just got started with the CA Reducing Disparities Project
- Housing is essential, especially with issues around federal funding decreasing
- State quality Improvement Council
- Data Quality and Improvement
- Compliance Advisory Council
- Lack of oversight stands out
- In the past, when counties were not being inclusive of Native Americans, we had a place to go: DMH. What will happen now?
- It takes time to get people to Stakeholder meetings
- Why is a meeting in Bay/Oakland/San Francisco not on the schedule?
- AB100 has an opportunity for reducing disparities.
- How do we meet the intentions of MHSA when the focus of services is on Medi-Cal? The funding is not there to support the goals of the MHSA.
- We need to address Prevention and Early Intervention.
- Will DMH be posting materials online? Including a transcript of the meetings?
- Office of Multicultural Services
  - Chief of OMS position needs to be restored
- It will be a good idea to engage un-served and underserved groups by speaking directly with the CRDP contractors:
  - Strategic Planning Workgroups
  - CA MHSA Multicultural Coalition
- Who is "the State"?
- Oversight is the most important state function
- Training and technical assistance needs to be provided to counties struggling with MHSA requirements
  - Include clients in the training – bring a perspective that is not always addressed.
- Local level needs to provide opportunities for inclusion of communities. The counties have to makes themselves open to that inclusion.
- MHSOAC adopted principles for oversight at the July 28th Meeting, the document is available online.
- A benefit of this transition is getting services to consumers faster. A challenge will be the [potential] continuation of money for ineffective programs [look at outcome and results].
- Transition Age Youth
- Which functions are necessary to meet federal requirements?
- There are a lot of functions on the list that are not just MHSA functions (OMS, etc.)
- Using Realignment terminology is confusing – not all aspects of Realignment II have passed

- Rebooting commitment to transformation, we can't let this opportunity to pass by. We need structure and leadership at the state level to keep it going.
- Juvenile justice – what is the role?
- Have regulations been modified to align with AB100?
- You are missing a whole segment of consumers and family members without access to computers; meeting notices could be posted at local pharmacies [as one additional avenue to reach out to stakeholders].
- There is no safety net for consumers. 911(not always a good option) Adult Protective Services (not always a good option)
- Early Mental Health Initiative (EMHI) is a priority and needs state oversight
    - Data is available to demonstrate effectiveness of the program
- Oversight and accountability at the state level
    - Look at findings of CRDP Reports
- Speaking as a family member with family only receiving Medi-Cal services money, we need to prioritize the following:
    - Older Adults
    - Integrating the system – MHSA
    - Out of county placements